CHRISTOPHER WAYNE LESTER

11 OF 14

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

OMB No.: 1215-0113
Expires: 10-31-99

ompletion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges r equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum eriod of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This rm must be signed and dated by the treating physician.

1 & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
O BOX 1113
ANVILLE, WV 25053

3. Telephone Number: (304) 347 - 6640

4. Social Security Number: [redacted]-3340

5. Date of Birth: [redacted]1971

6a. Date(s) of last hospitalization
From: 8/1/02
To: 8/9/02

6b. Condition(s) treated while in hospital
ACUTE SUDDEN SYNCOPE WITH RIGHT HEMIPARESIS
SEVERE DECAPACITATING LOW BACK PAIN

7. DIAGNOSIS for which this prescription is written:
- SEIZURE DISORDER
- CHRONIC BACK PAIN WITH FREQUENT FALLS

8a. Type of Prescription
☒ Original (New)
☐ Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 08-15-02 Ending Date: 08-14-03

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

☐ Tank O_2 With Flowmeter and Humidifier ☐ O_2 Concentrator ☐ O_2 Liquid System
☐ Portable Unit (Gaseous) ☐ O_2 Liquid System With Portable Liquid

9b. Other DME
☐ Manual Hospital Bed (11c.) ☐ Commode (11f.)
☐ Semi-electric Hospital Bed (11c.) ☐ Wheelchair (11g.)
☐ Nebulizer with Motor (11a.) ☒ Other (Explain in item no. 12.)

9c. Prescription for Medical Services
☐ Pulmonary Rehabilitation Services (See 11e.)
Level: _____
☐ Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition: ☐ Acute ☐ Chronic
Results: (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (If "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: ☐ Good ☐ Fair ☐ Poor
Miner's ability to understand instructions and follow directions: ☐ Good ☐ Fair ☐ Poor

C. Was equipment calibrated before the test? ☐ Yes ☐ No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition: ☐ Acute ☐ Chronic

Results:	PO_2	PCO_2	PH

F. Air Intake: ☐ On room air ☐ On O_2 @ ____ LPM

G. Time Sample Drawn _____ Iced ☐ Yes ☐ No Time Sample Analyzed _____

H. Was equipment calibrated before the test? ☐ Yes ☐ No

I. Testing Facility Name and Address

Form CM-893
Rev. Dec. 1990

500688.061.0071

11. DOL/DCMWC REIMBURSEMENT STANDARDS

1a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 60% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

1b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

1c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

1d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

1e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

1f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment.
Objective test requirements: for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

1g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

1h. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

2. Comments:

GRAB BAR - E0241 , HEAVY DUTY SHOWER BENCH- E0245

HEAVY DUTY WALKER- E0148

3. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)

EBENEZER OBENZA
333 LAIDLEY STREET
CHARLESTON, WV 25301

(304)347-6640

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☐ No ☑

If NO, explain why you are prescribing the equipment or services on this form. ATTENDING PHYSICIAN ON PATIENT'S RECENT HOSPITALIZATION.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 8 | 8 | 02 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: 8 | 9 | 02 (MM DD YY)

I. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date 8/6/02

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072. (In MD.: 1-800-492-5737)

I. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:

BOONE HOMECARE SUPPLIES PROVIDER#
327 STATE STREET 55-0739015-001
MADISON, WV. 25130 (304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

SAINT FRANCIS HOSPITAL

FACSIMILE

TO: Boone Home Health 369-7005

FROM: Saint Francis 4 West

CONTACT #: 347-6532

DATE: 8-8-02

FAX #: 347-6596

OF PAGES: 3 including coversheet

COMMENTS:

Orders for Christopher Lester

08-09-02 08:25 From-

T-267 P.01/05 F-596

SAINT FRANCIS HOSPITAL

333 Laidley Street
PO Box 471
Charleston, WV 25322
(304) 347-6600

QUALITY RESOURCE MANAGEMENT
Telephone (304) 347-6640 Fax (304) 347-6728

FACSIMILE COVERSHEET

TO: Boone Medical Supply

FROM: Leigh D'Agostino, R.N.

CONTACT #: 330-1818

DATE: 8/8/02

FAX #: 369-7005

 # OF PAGES: 5 including coversheet

COMMENTS:

313696

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7961

for 7/023/02

DATE 8-9-02

NAME Christopher Lester

ADDRESS [redacted] 3340

CITY, STATE, ZIP [redacted] 1971 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2				
3	6	Biofreeze	60	00
4				
5				
6	2	Tens lotion	15	00
7				
8				
9		A4595 DU - 2 -	75	00
10				
11		John M Snyder		
12				
13		7242		
14				
15		20000468 41		
16				
17		Billed $160.00		
18				
			TAX	
			TOTAL	

RECEIVED BY April Foster

35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

07/23/02 12 A4595 NU 75.00 02

313696 75.00 0.00 75.00

Signature On File
08/16/02

5507390150

500688.061.0076

08-09-02 08:25 From- T-267 P.02/05 F-688

Patient Name	Unit #	Service/Location	Status	Date	
LESTER,CHRISTOPHER W	HC00261190	TELEMETRY	ADM IN	08/01/02	H02532760280

Soc Sec No DOB Age Sex MS Race Religion [redacted]-3340 [redacted]/71 30 M M W NONE		UNEMPLOYED
Address: P O BOX 1113 DANVILLE,WV 25053	USA	ENGLISH
Home Ph: (304)369-6657	County: BOONE	Work Phone: Occupation:
LESTER,CHRISTOPHER W Address: P O BOX 1113 DANVILLE,WV 25053	SS#: 239-15-3340 USA	UNEMPLOYED
Home Ph: (304)369-6657 Relationship to Patient: PATIENT	County: BOONE	Work Phone: Occupation:
LESTER,APRIL C Address: Home Ph: 304-369-6657 Relationship to Patient:	SS#: County:	BOONE COUNTY COMMISSION Work Phone: Occupation:
BROWNING,GINA Home Phone: (304)369-2152 Relationship to Patient: SISTER	Work Phone:	LESTER,APRIL C Home Phone: (304)369-6657 Relationship to Patient: WIFE
WORKERS COMPENSATION PO BOX 3151 CHARLESTON, WV 25332 USA Phone (304)348-2580	Policy [redacted]0340 Birthdate [redacted]/71 Subscriber LESTER,CHRISTOPHER W Rel to Pt PATIENT Eff. to Group 9999 WORKERS COMPENSATION	Precert Ins Verif Not Requ Auth # Date Contact
	Policy # Birthdate Subscriber Rel to Pt Eff. to Group	Precert Ins Verif Auth # Date Contact
	Policy # Coverage # Subscriber Rel to Pt Eff. to Group	Precert Ins Verif Auth # Date Contact

Code Type	Date	Time	Code Type
04 EMPLOYMENT RELATED	03/10/09	0000	02 EMPLOYMENT RELATED

Admission Comment	Financial Class
PT SAID TO BILL WC	04

Attending Physician	HCIS	Admitting Physician	HCIS	Emergency Room Physician	HCIS
Obenza,Ebenezer J	5010	Obenza,Ebenezer J	5010	Stewart,Edward E Jr.	6437
Primary Care Physician	HCIS	Family Physician	HCIS	Other Physician	
SNYDER,JOHN MARK	9999	(u)SNYDER,JOHN MARK			

Date	Time	Source	Rm/Bed	Arrival	Principal Admitting Diagnosis/Reason For Visit	Clerk
08/01/02	1846	EMERGENCY ROOM	446/1	WHE	ALTERED MENTAL STATUS. RIGHT HEMISPHERIC CVA. COMP	HADLAP

ADMISSION FORM HCA Saint Francis Hospital 08/09/02 0801

SAINT FRANCIS HOSPITAL

Patient Name: LESTER,CHRISTOPHER W MR Number: H0002611190

Attending Physician: Obenza,Ebenezer J Room Number: H.446

Date of Admission: 08/01/02 Patient Status: ADM IN

5'8" 293 lbs.

IDENTIFICATION: CHRISTOPHER W LESTER

CHIEF COMPLAINT/
HISTORY OF PRESENT ILLNESS: This is a thirty year old white male who is admitted to Saint Francis Hospital on 08/01/2002. The patient has been admitted with a diagnosis of altered mental status, right hemispheric cerebrovascular accident, and complex chronic pain syndrome. The patient stated that last week, while he was working at home, he almost passed out. At that time he started developing some numbness and tingling in the left upper and lower extremity. The patient states he was taken to Boone Memorial Hospital where a CT scan was done. He was then transferred to Charleston Area Medical Center General Division. At that time the CT scan was normal. The patient states that he was then discharged. The patient continued to have weakness and numbness on his right side. The patient states that into the week he got incontinent and had no control of his bladder. At that time the patient decided to come to Saint Francis Hospital Emergency Department. The patient had another CT scan done which was abnormal. The patient has been admitted for further evaluation. The patient continues to have some tingling in his right upper and lower extremity, mainly in the lower extremity. The patient denies any chest pain or shortness of breath. The patient denies any nausea or vomiting. The patient denies being incontinent at this time.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS:
1. OxyContin.
2. Flexeril.
3. Trazodone.
4. Paxor.

PAST MEDICAL HISTORY: Significant for depression, anxiety, and back injury. The patient has chronic low back pain.

SOCIAL HISTORY: The patient denies any alcohol, tobacco or drug use. The patient is married and lives at home.

FAMILY HISTORY: Significant for hypertension, tuberculosis, asthma, cancer and diabetes.

REVIEW OF SYSTEMS: As per History of Present Illness, otherwise unremarkable.

PHYSICAL EXAMINATION:

GENERAL: A thirty year old white male in no acute distress. He is

re: LESTER,CHRISTOPHER W
MR#: H000261190

alert and oriented.

VITAL SIGNS: Blood pressure 120/68. Temperature 98.6. Pulse 98. Respirations 20. Weight 292 pounds. Oxygen saturation 97%.

HEENT: Atraumatic, normocephalic. Sclerae are clear. Ears and nose are without any discharge. Oral mucosa is pink and moist. Throat is clear.

NECK: Supple. No lymphadenopathy.

CHEST: Symmetrical.

HEART: Regular rate and rhythm.

LUNGS: Clear.

ABDOMEN: Obese and soft, non-tender, and non-distended. No hepatomegaly or masses noted.

EXTREMITIES: No cyanosis, clubbing, or edema.

RECTAL/GENITALIA: Examination deferred.

NEUROLOGICAL: Cranial nerves are grossly intact.

LABORATORY/X-RAY FINDINGS: White count 8.2, hemoglobin 15.5, hematocrit 45.4 with platelets of 247,000. Sodium 139, potassium 4.1, chloride 97, CO2 36, glucose 92, BUN 15, creatinine 1.5. CK 48, CK-MB 0.2, Troponin-I 0.08, and myoglobin 49.

Arterial blood gas showed a pH of 7.431, PCO2 40, PO2 77, bicarbonate 96, base excess of 2 and oxygen saturation of 97%.

ASSESSMENT:
* A thirty year old male admitted with alternated mental status, right hemispheric cerebrovascular accident, complex chronic pain syndrome, urinary incontinence, etiology uncertain.
* History of chronic pain back.

PLAN;B For further plan, please see Dr. Obenza's admitting orders.

Job #: 234803

Misaghi,Faredoon

Obenza,Ebenezer J

D: 08/04/02 1633 / MISFA
T: 08/04/02 2020 / AKL

HISTORY AND PHYSICAL

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
(304)369-7964 OR FAX (304)369-7005
KATHLEEN S. ELLIS

CERTIFICATE OF MEDICAL NECESSITY: **UROLOGICAL SUPPLIES**

PATIENT'S NAME CHRISTOPHER LESTER PHONE (304)369-6657

PATIENT'S ADDRESS PO BOX 1113

DANVILLE, WV 25053

HICN _____ THIS CMN IS THE XX INITIAL _____ REVISED

PLACE OF SERVICE: 12

▶ ***BELOW TO BE COMPLETED ONLY BY PHYSICIAN OR PHYSICIAN'S EMPLOYEE*** ◀

DIAGNOSIS: (ICD9) 596.54

DOB: [redacted] / [redacted] / 1971 DATE NEEDED INITIAL 08 / 08 / 2002 REVISED ____ / ____ / ____

ESTIMATED LENGTH OF NEED: # MONTHS: _____ 1-99 (99=LIFE)

I LAST EXAMINED PATIENT FOR THIS CONDITION ON: 8 / 8 / 02

PATIENT SEX: MALE (MALE OR FEMALE)

Use Y-yes, N-no

(Y) 4. Does the patient have permanent urinary incontinence?

5. Reason if excess supplies are required: _____

supplies:	***HCPC***	***frequency of change***
FREEDOM CONDOM CATHS	A4358	prn
LEG BAGS	A34358	prn
NIGHT TIME DRAIN BAGS	A4357	prn

I certify the medical necessity of these items for this patient. This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN'S NAME AND ADDRESS
FREDERICK C MARTINEZ
400 COURT STREET
CHARLESTON, WV 25301

PHYSICIAN'S SIGNATURE (NO STAMP)

DATE _____

☐ ATTENDING ☒ CONSULTING ☐ OTHER ORDERING

PHONE (304)347-6640 UPIN _____

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number
(304) 369-6657

4. Social Security Number
[redacted]3340

5. Date of Birth
[redacted]/1971

5a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
Neurogenic Bladder

8a. Type of Prescription
- [X] Original (New)
- [ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 08/08/02
Ending Date: 08/07/02

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.)
Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

- [ ] Tank O_2 With Flowmeter and Humidifier
- [ ] O_2 Concentrator
- [ ] O_2 Liquid System
- [ ] Portable Unit (Gaseous)
- [ ] O_2 Liquid System With Portable Liquid

9b. Other DME
- [ ] Manual Hospital Bed (11c.)
- [ ] Semi-electric Hospital Bed (11c.)
- [ ] Nebulizer with Motor (11a.)
- [ ] Commode (11f.)
- [ ] Wheelchair (11g.)
- [X] Other (Explain in item no. 12.)

9c. Prescription for Medical Services
- [ ] Pulmonary Rehabilitation Services (See 11e.)
  Level: _____
- [ ] Home Nursing Care (See 11d.)

10. Objective Test Results – Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition:
- [ ] Acute
- [ ] Chronic

Results: (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition:
- [ ] Acute
- [ ] Chronic

Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ___ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

Form CM-893
Rev. Dec. 1990

500688.061.0081

11. DOL/DCMWC REIMBURSEMENT STANDARDS

a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment. **Objective test requirements:** for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

h. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:
A4324: FREEDOM CONDOM CATHS A4358: LEG BAGS A4357: NIGHT TIME DRAIN BAGS

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)
FREDERICK C MARTINEZ
400 COURT STREET
CHARLESTON, WV 25301
(304)347-6640

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☐ No ☒
If NO, explain why you are prescribing the equipment or services on this form.
Urology (specialist)

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 8/8/02 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: ___/___/___ (MM DD YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date: 8/13/02

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072. (In MD.: 1-800-492-5737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES PROVIDER#
327 STATE STREET 55-0739015-001
MADISON, WV. 25130 (304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

029664

DATE 5-23-02

NAME Christopher Slater

ADDRESS [redacted] 3340

CITY, STATE, ZIP [redacted] 971 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	6	Biofreeze @ 10.00		60.00
2				
3	2	Tens Unit Lotion @7.50		15.00
4				
5				
6		AC4595N4		27.50
7				
8		Chris		
9				
10				
11				75.00
12				
13		John H Snyder		
14				
15		7242	Billed	
16			5-24-02	
17		2000046841		
18				
RECEIVED BY			TAX	
			TOTAL	

adams 25805

A [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

05/23/02 12 A4595 NU 75.00 02

029664 75.00 0.00 75.00

Signature On File
05/24/02 5507390150

500688.061.0084

175713

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

Comp.

DATE 3-8-02

NAME Christopher Lester

ADDRESS [redacted] 3340 (12830)

CITY, STATE, ZIP [redacted] -1971

ORDER NO.	SOLD BY		C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2				
3	6	Bio-freeze		
4		A101-20	60	00
5				
6				
7	2	Tens Lotion	15	00
8				
9		03102000	75	00
10		John M Snyder		
11		7242		
12		20006408411 Chris Lester	D.L.D. 3-10-02	
13				
14				
15				
16				
17		A4595 2-75.00		
18				
RECEIVED BY			TAX	
			TOTAL	

35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

03/08/02 12 A4595 75.00 02

175713 75.00 0.00 75.00

Signature On File
03/29/02 5507390150

500688.061.0086

429800

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

4-80 D

DATE 4/1/02

NAME Christopher Reston
ADDRESS [redacted] 3340
CITY, STATE, ZIP [redacted] 197

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	6	Diafrezil @ 10.00		60 00
2	2	Tera Lotion @ 7.50		15 00
3				
4		03102000		75 00
5				
6		John H Snyder		
7				
8		1242		
9				
10		200004484		
11				
12		billed		
13		4120		
14				
15				
16				
17		A4595 2-75.00		
18				
RECEIVED BY			TAX	
			TOTAL	

adams
25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

04/08/02 12 A4595 NU 75.00 02

429800 75.00 0.00 75.00

Signature On File
04/12/02

5507390150

0

500688.061.0088

887989

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 1/02

NAME Christopher Lester
ADDRESS [redacted] 3340
CITY, ST [redacted] 1971 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	2	~~#643 electrodes @ [illegible]~~		~~[illegible]~~
2	3	#2404 electrodes @ 12.00		36 00
3	2	lotion @ 7.50		15 00
4				
5				~~[illegible]~~
6	1	electrode #643		14.00
7	10	#E LOBT electrodes		10.00
8				
9				75.00
10				
11				
12		John M Snyder		
13				
14		742		
15		2066646841		
16				
17		1-10-02 A4595 2-75.00		
18		2-10-02 A4595 2-75.00		
		TAX		
		TOTAL		

RECEIVED BY Billed 2-22-02

adams
35805

500688.061.0089

887988

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 2/14/02

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2		Tens supplies		
3				
4	~~40 #E4067~~			~~40 00~~
5	3	Bifreeze @ 10.00		30 00
6	~~25~~			
7	1	#643 electrodes		14 00
8	31	#E4067 electrodes		31 00
9				
10				75.00
11				
12				
13				
14				
15				
16				
17				
18				
RECEIVED BY			TAX	
			TOTAL	

35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

01/10/02	12	A4595	75.00	02
02/10/02	12	A4595	75.00	02

887989 150.00 0.00 150.00

Signature On File
02/22/02

5507390150

0

500688.061.0091

287869

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 11-10-01
11/16/01

NAME Christopher Lester
ADDRESS [redacted] 3340
CITY, STATE, ZIP [redacted] 1971 12178

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2	1	9V Duracell 4.50 BA-02		
3				
4	1	653 Electrodes 14.00		
5				
6	3	1704 Electrodes 12.00		
7				
8	3	640 Electrodes 8.00		
9				
10	1	Tens Unit Action 2.50		
11				
12		03102000		
13		John M Snyder		
14		7242	1/4.00	
15		200004684		
16		A4595 8-75.00		
17		Billed 11-3001		
18				
			TAX	
			TOTAL	

RECEIVED BY

adams
35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Com

X

00000000

JOHN M SNYDER 00/00/00 00/00/0(

7242

2000046841

11/10/01 12 A4595 75.00 02

287869 75.00 0.00 75.0

Signature On File
11/30/01

0 550739015

500688.061.0093

308641

Comp

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 10-10-01

NAME Christopher Lester Workers Comp

ADDRESS [redacted] 3340 DOI 7242

CITY, STATE, ZIP [redacted] 1971 2000046841

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
					7242		

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	1	TensUnit 2000-TPlus		
2		Serial # R0601137 89		
3		Lumiscope John M Snyder		
4				
5		E0720 1-50.00		
6				
7				
8				
9				
10				
11		Paid 11-2-01		
12				
13				
14				
15				
16				
17				
18				

RECEIVED BY Chris Lester

TAX

TOTAL

adams 35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

10/10/01 12 E0720 50.00 01

10/10/01 0.00 00

308641 50.00 0.00 50.00

Signature On File
11/02/01

5507390150

0

500688.061.0095

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number
(304) 369-6657

4. Social Security Number
[redacted]-3340

5. Date of Birth
[redacted]/1971

6a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
Chronic low back pain

8a. Type of Prescription
[X] Original (New)
[ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 10/10/01
Ending Date: 10/09/02

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

[ ] Tank O_2 With Flowmeter and Humidifier
[ ] O_2 Concentrator
[ ] O_2 Liquid System
[ ] Portable Unit (Gaseous)
[ ] O_2 Liquid System With Portable Liquid

9b. Other DME
[ ] Manual Hospital Bed (11c.)
[ ] Semi-electric Hospital Bed (11c.)
[ ] Nebulizer with Motor (11a.)
[ ] Commode (11f.)
[ ] Wheelchair (11g.)
[X] Other (Explain in item no. 12.)

9c. Prescription for Medical Services
[ ] Pulmonary Rehabilitation Services (See 11e.)
Level: _____
[ ] Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition:
[ ] Acute
[ ] Chronic
Results: (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition:
[ ] Acute
[ ] Chronic
Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ____ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

RECEIVED OCT 17 2001

Form CM-893
Rev. Dec. 1990

500688.061.0096

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

11b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 65 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

11c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment.
Objective test requirements: for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

11g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11h. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:

E0720: TENS UNIT & SUPPLIES

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)

JOHN M SNYDER
705 MADISON AVENUE
MADISON, WV 25130
(304)369-5170

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☑ No ☐

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 10 (MM) 10 (DD) 01 (YY)

d. Date that the prescribed treatment or service is authorized to begin: 10 (MM) 10 (DD) 01 (YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date 10/19/01

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim.
For further information call TOLL FREE:
1-800-638-7072. (In MD.: 1-800-492-5737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES PROVIDER#
327 STATE STREET 55-0739015-001
MADISON, WV. 25130 (304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

305191

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130

DATE 12-7-00

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
	ISO						

QUAN.	DESCRIPTION	PRICE	AMOUNT
1	1 Rib Belt 8" #4113-00		
2	Male Universal		
3	L0500		100 00
4			
5	Agm # 20000 46841		
6	DOS 3-10-00		
7			
8	PX 1242		
9			
10			
11			
12			
13	Billed		
14			
15	1-12-01		
16			
17			
18			
	RECEIVED BY April Lester	TAX	
		TOTAL	

Adams
25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN SNYDER 00/00/00 00/00/00

7242

2000046841

12/07/00 12 L0500 100.00 01

305191 100.00 0.00 100.00

Signature On File
01/12/01

5507390150

0

500688.061.0099

VERIFIED BY FAX PDF

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number
(304) 369-6657

4. Social Security Number
[redacted]-3340

5. Date of Birth
[redacted]1971

6a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
lumbar sprain
847.2

8a. Type of Prescription
☒ Original (New)
☐ Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 12/28/00 Ending Date: 12/27/01

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

☐ Tank O_2 With Flowmeter and Humidifier ☐ O_2 Concentrator ☐ O_2 Liquid System
☐ Portable Unit (Gaseous) ☐ O_2 Liquid System With Portable Liquid

b. Other DME
☐ Manual Hospital Bed (11c.) ☐ Commode (11f.)
☐ Semi-electric Hospital Bed (11c.) ☐ Wheelchair (11g.)
☐ Nebulizer with Motor (11a.) ☒ Other (Explain in item no. 12.)

c. Prescription for Medical Services
☐ Pulmonary Rehabilitation Services (See 11e.) Level: _____
☐ Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition: ☐ Acute ☐ Chronic
Results: (Best Effort)

	Predicted	Bronchodilation Before	Bronchodilation After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: ☐ Good ☐ Fair ☐ Poor
Miner's ability to understand instructions and follow directions: ☐ Good ☐ Fair ☐ Poor

C. Was equipment calibrated before the test? ☐ Yes ☐ No

D. Testing Facility Name and Address:

Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition: ☐ Acute ☐ Chronic
Results:

PO_2	PCO_2	PH

F. Air Intake: ☐ On room air ☐ On O_2 @ ___ LPM

G. Time Sample Drawn _____ Iced ☐ Yes ☐ No Time Sample Analyzed _____

H. Was equipment calibrated before the test? ☐ Yes ☐ No

I. Testing Facility Name and Address

Form CM-593
Rev. Dec. 1990

Copied 01-10-00

RECEIVED JAN 0 2 2001

500688.061.0100

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. For nebulizer equipment with compressor motor: requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodiliation; or FEV_1 of 1.0L or less (See 11h).

11b. For Home O_2 delivery equipment: requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

11c. Hospital bed: must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. Prescriptions for home care: must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. Prescription for pulmonary rehabilitation services: must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. Commodes: will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment. Objective test requirements: for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

11g. Wheel chairs: are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11h. ALL CMN supportive test results: must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:
RIB BELT

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)
JOHN SNYDER
705 MADISON AVENUE
MADISON, WV 25130
(304)369-5170

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☑ No ☐

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 12/29/01 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: 12/29/01 (MM DD YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date: 1-4-02

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL-FREE: 1-800-638-7072. (In MD.: 1-800-492-5737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
(304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of RIM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

264324

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 9/14/00

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
	8843						

QUAN.	DESCRIPTION	PRICE	AMOUNT
1	~~Cane~~		
2			
3	Adjustable Cane		
4	E0100		22 00
5			
6	D.O.I. 3-10-00		
7			
8	Claim # 20000 76841		
9			
10	DX 724.2		
11			
12			
13			
14	Billed 10-3-00	Pd 22 00 9-00	
15			
16			
17			
18			
	RECEIVED BY Chris Lester	TAX	
		TOTAL	

Adams
25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER DO 00/00/00 00/00/00

7242

2000046841

09/14/00 12 E0100 22.00 01

264324 22.00 0.00 22.00

Signature On File
10/03/00

5507390150

0

500688.061.0103

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number
(304) 369-6657

4. Social Security Number
[redacted]-3340

5. Date of Birth
[redacted]/1971

6a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
chronic back pain,

8a. Type of Prescription
- [X] Original (New)
- [ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 09/13/00
Ending Date: 09/12/01

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

- [ ] Tank O_2 With Flowmeter and Humidifier
- [ ] O_2 Concentrator
- [ ] O_2 Liquid System
- [ ] Portable Unit (Gaseous)
- [ ] O_2 Liquid System With Portable Liquid

9b. Other DME
- [ ] Manual Hospital Bed (11c.)
- [ ] Semi-electric Hospital Bed (11c.)
- [ ] Nebulizer with Motor (11a.)
- [ ] Commode (11f.)
- [ ] Wheelchair (11g.)
- [X] Other (Explain in item no. 12.)

9c. Prescription for Medical Services
- [ ] Pulmonary Rehabilitation Services (See 11e.)
  Level: _____
- [ ] Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition:
- [ ] Acute
- [ ] Chronic

Results: (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition:
- [ ] Acute
- [ ] Chronic

Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ____ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

RECEIVED SEP 19 2000

Form CM-893
Rev. Dec. 1990

500688.061.0104

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

11b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

11c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment.
Objective test requirements: for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

11g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11h. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:

E0100: ADJUSTABLE CANE

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)

JOHN M. SNYDER
705 MADISON AVENUE
MADISON, WV 25130
(304)369-7964

b. Are you the patient's regular physician or are you actively treating this patient? Yes [✓] No [ ]

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 8 / 13 / 02 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: 8 / 13 / 02 (MM DD YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date: 8/01/02

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072. (In MD.: 1-800-492-5737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES PROVIDER#
327 STATE STREET 55-0739015-001
MADISON, WV. 25130 (304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Christopher W. Lester DATE 9-14-00

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Christopher W. Lester

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PHYSICIAN OR SUPPLIER INFORMATION

500688.061.0106

Telephone: (304) 369-5170 DEA #AS 3212329

JOHN M. SNYDER, D.O.

705 Madison Avenue Madison, WV 25130

Name Christopher Lech Date 9/27/00

Address

℞ W.C.1

Cane

M. back

Thumb pain

☐ Label

Refill

D.O.

This prescription may be filled with a generically equivalent drug product unless the words "Brand Necessary" or "Brand Medically Necessary" are written, in the practitioner's own handwriting, on this prescription form.

Telephone: (304) 369-6170 DEA #AS 3212329

JOHN M. SNYDER, D.O.

705 Madison Avenue Madison, WV 25130

Name Charles Lark Date 10/10/01

Address

℞ TENS unit wc.

D.O.

☐ Label

Refill - 0 - 1 - 2 - 3 - 4 - PRN

This prescription may be filled with a generically equivalent drug product unless the words "Brand Necessary" or "Brand Medically Necessary" are written, in the practitioner's own handwriting, on this prescription form.

FREDERICK C. MARTINEZ, M.D., F.A.C.S.
ADULT AND PEDIATRICS UROLOGY
400 COURT STREET
CHARLESTON, WV 25301
(304) 347-8206
DEA #
LIC. # 19536

NAME Christopher Listen AGE

ADDRESS DATE 1/8/02

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞

Freedom Condom Cath
Disp: 1 mo. supply
Refill x 5

Refill x 5 (five) times

☐ Label

(Signature)

This prescription may be filled with a generically equivalent drug product unless the words "BRAND NECESSARY" or the words "BRAND MEDICALLY NECESSARY" are written, in the practitioner's own handwriting, on this prescription form.

2DUR5012128

FREDERICK C. MARTINEZ, M.D., F.A.C.S.
ADULT AND PEDIATRICS UROLOGY
400 COURT STREET
CHARLESTON, WV 25301
(304) 347-6290
DEA #
LIC. # 19838

NAME Christopher Lester AGE
ADDRESS DATE 8/1/02

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞
Overnight urinary
drainage bag
Disp. #3 Refill x 3

Leg bag
Disp. #3 Refill x 3

Refill ______ times

☐ Label

(Signature)

This prescription may be filled with a generically equivalent drug product unless the words "BRAND NECESSARY" or the words "BRAND MEDICALLY NECESSARY" are written, in the practitioner's own handwriting, on this prescription form.

2DUR5012128

Telephone: (304) 369-5170 DEA #AS 3212329

JOHN M. SNYDER, D.O.

705 Madison Avenue Madison, WV 25130

Name [illegible] Date 8-31-a

Address

℞ Sleepiz medic

☐ Label

Refill - 0 - 1 - 2 - 3 - 4 - PRN

[signature], D.O.

This prescription may be filled with a generically equivalent drug product unless the words "Brand Necessary" or "Brand Medically Necessary" are written, in the practitioner's own handwriting, on this prescription form.

Telephone: (304) 369-5170 DEA #AS 3212329

JOHN M. SNYDER, D.O.

705 Madison Avenue Madison, WV 25130

Name Chris Lash Date 3-6-02

Address

℞ Moist heating pad

Mr. Charm #150

workers comp

D.O.

This prescription may be filled with a generically equivalent drug product unless the words "Brand Necessary" or "Brand Medically Necessary" are written, in the practitioner's own handwriting, on this prescription form.

☐ Label

Refill - 0 - 1 - 2 - 3 - 4 - PRN